Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: NOVA HEALTHCARE CENTERS 110 CYPRESS STATION STE 280 HOUSTON TX 77090	MFDR Tracking #: M4-10-4227-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: OLD GLORY INSURANCE CO REP BOX # 11	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "According to The Texas Labor Code section 408.027, and Division rule 133.20, provider must submit a bill by the 95th day following the date of service. The word, "submit", is used in the same manner as "sent". Rule 102.4(h) describes the determination of when documents are sent: 1. **The date received** if sent by fax, personal delivery, or electronic transmission. 2. **The date postmarked** if sent by mail via US Postal Service regular mail. 3. If postmark is not available, the latter of the **signature date on the written communication or the date it was received minus five (5) days, including Saturday.** Please find enclosed a HCFA 1500 form, your EOB, medical records, and proof of timely filing."

Principal Documentation:

1. DWC060
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $1,720.11

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The documentation the provider has submitted as proof of timely filing, does not appear to show to whom or where the bill was submitted. Based on the submitted documentation, we are unable to overturn our previous denial. Attached, please find copies of the billings, explanations of benefits and medical on the above referenced.

1. DWC060

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
04/03/2009, 04/07/2009, 04/08/2009, 04/09/2009, 04/14/2009, 04/17/2009 04/20/2009	29, 138, 193	CPT Codes 99203, 97035, 97535, 97112, 97110, 99080-73 and HCPCS Code L3908	$1,720.11	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason codes:
   - 29 – The time limit for filing has expired;
   - 138 – Appeal procedures not followed or time limits not met; and
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Final adjudication. NOTES: Proof of timely filling must be either a signed certified mail receipt, faxed confirmation or electronic billing. In additional, timely filing for a reconsideration is 11 months and that has expired as well. Denial is maintained for timely filing.

2. In accordance with 28 Tex. Admin. Code Section §133.307(c)(1)(A) the Requestor has not submitted the request for medical fee dispute resolution within one year of the disputed dates of service. The disputed dates of service are listed as April 3, 2009 through April 20, 2009; the Division received the dispute June 2, 2010. Therefore, per Tex. Admin. Code Section §133.307(e)(3)(E) the request for medical fee dispute resolution is untimely and outside the jurisdiction of Medical Fee Dispute Resolution.

3. The Division concludes that this dispute was not filed in the form and manner prescribed under §133.307. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		August 18, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.